MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-003507
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 108

FILED JAN 11 1962

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP #1. Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1213A Clinton St. Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First FLORENCE Middle Last BOOS

4. DATE OF DEATH Month Day Year JAN. 3, 1962

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 6-16-1897
9. AGE (last birthday) 64
IF UNDER 1 YEAR Months Days
IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE FACTORY
10b. KIND OF BUSINESS OR INDUSTRY SHOE MANUFACTURING
11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME WILLIAM BOOS
13b. MOTHER'S MAIDEN NAME ANNA RATHERT
14. NAME OF HUSBAND OR WIFE NEVER MARRIED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO.
17. INFORMANT Address FRANCES M. BOOS 1213A CLINTON ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:)
IMMEDIATE CAUSE (a) Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arterial hypertension — 6 days
DUE TO (c) 330 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/26/61 to 1/3/62 and last saw her/him alive on 1/3/62
Death occurred at 10:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Carl H. Linkenheger M.D.
22b. ADDRESS 1515 LAFAYETTE AVE
22c. DATE SIGNED 1/3/62

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 1-5-1962
23c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery
23d. LOCATION (City, town, or county) (State) NORMANDY MO.

24. FUNERAL DIRECTOR ADDRESS Jos. W. CLARK F.H. 1125 HODIAMONT
25. DATE RECD. BY LOCAL REG. JAN 4 1962
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4511

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.